STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505362	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST VIEW TRANSITIONAL HEALTH CENT	5129 HILLTOP ROAD EVERETT, WA 98203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS An unannounced Life Safety Code Survey was conducted at Forest View Transitional Health Center, Everett, Washington, on October 15, 2013 by staff from the Washington State Patrol, Fire Protection Bureau, Oak Harbor Detachment. The 2000 existing edition of the Life Safety Code was utilized for the survey in accordance to 42 CFR 483.70: Requirements for Long Term Care. The LTC 70 bed facility with a census of 63, consisted of a Type V-111, 2 story structure, with a basement (used for environmental care purposes) and was built in 1999. The facility is fully sprinkled with an automatic fire alarm system in place. Exit discharge points are to grade and have an all weather surface and lead to a public way. The deficiencies identified during this survey are listed below. The facility is not in compliance with the Life Safety Code 2000 Edition as adopted by C.M.S. [redacted] Paul V Schwab Deputy State Fire Marshal	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Regency Care Center at Forest View does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050	**K050** **Plan to correct identified findings:** An education was performed to the Maintenance Director to ensure Fire Drills are held at unexpected times under varying conditions, at least quarterly on each shift. **Identification similar situation:** An education was performed to the Maintenance Director to ensure Fire Drills are held at unexpected times under varying conditions, at least monthly and on random rotations. **Measures to prevent recurrence:** Maintenance Director has been provided forms for tracking fire drills. The Maintenance Director has been signed up for the TELS program to monitor, track, and trend fire drills. **Monitor to sustain compliance:** The Maintenance Director and/or designee will audit the process of fire drills at unexpected times. Results will be forwarded to Quality Assurance Committee for the next 90 days	11-8-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Administrator	Administrator	10-24-13

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	505362	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/15/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST VIEW TRANSITIONAL HEALTH CENT	**5129 HILLTOP ROAD EVERETT, WA 98203**

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K 050	Continued From page 1 This Standard is not met as evidenced by: Based on record review, the facility failed to assure that the LTC staff was adequately trained to respond to fires. This potentially exposed residents to smoke and fire in the facility. Findings include: An examination of the facility ' s fire drill records on October 15, 2013 at 12:40 PM revealed that the fire drill records were not conducted for: 1. 3rd qtr, 2013 (months Jul/Aug/Sept) These findings were acknowledged by the Maintenance Director.	K 050	**K076** **Plan to correct identified findings:** Oxygen Cylinders were immediately secured on second floor and first floor. **Identification similar situation:** An audit was complete of the Oxygen Cylinders in the facility to ensure proper storage. **Measures to prevent recurrence:** An education has been performed to the licensed staff on securing Oxygen Cylinders on the first and second floor. A random audit will be completed by the Maintenance Director and/or designee to ensure proper storage and educate when necessary. **Monitor to sustain compliance:** A random audit will be completed by the Maintenance Director and/or designee to ensure proper storage. Results will be forwarded to the Quality Assurance Committee for the next thirty days..	11-8-13
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This Standard is not met as evidenced by: Based on observation and staff interview the facility failed to maintain medical gas storage in accordance to NFPA 99,4-3.1.1.2. This has the	K 076		

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	505362	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/15/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST VIEW TRANSITIONAL HEALTH CENT	**5129 HILLTOP ROAD EVERETT, WA 98203**

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K 076	Continued From page 2 potential for a fire and explosive hazard exposure to the residents. This potentially exposed residents to a missile hazard during fire conditions. Findings include: During the facility tour on October 15, 2013 from 9:30 AM AM to 1:45 PM. It was observed that: 1. 2nd floor oxygen storage room - 3 cylinders unsecured 2. 1st floor oxygen storage room - 4 cylinders unsecured. These findings were acknowledged by the facility Maintenance Director.	K 076	**K130** **Plan to correct identified findings:** CO 2 Detector in hallway of second floor was installed CO2 2 Detector in hallway of first floor was installed CO2 detector in Resident Room 102 was installed **Identification similar situation:** An education will be performed to staff regarding CO2 Detectors installed, the sound and the procedure in case alarms. **Measures to prevent recurrence:** Battery Power checks will be performed monthly on CO2 detectors and reported to Quality Assurance Committee for 90days. A random audit will be completed by the Maintenance Director and/or designee to ensure staff education and awareness of CO2 Detectors for the next 30days. **Monitor to sustain compliance:** Battery Power checks will be performed monthly on CO2 detectors and reported to Quality Assurance Committee for 90days. A random audit will be completed by the Maintenance Director and/or designee to ensure staff education and awareness of CO2 Detectors and forwarded .Quality Assurance Committee for the next thirty days.	11-8-13
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This Standard is not met as evidenced by: Based on observations, the facility did not have Carbon Monoxide Detectors installed in the building in accordance with NFPA Standard 720 2012 edition. This has the potential of having a leak with no detection that would expose residents, visitors and staff to a hazardous environment. The findings are as follows: During the facility tour on October 15, 2013 from 9:30 AM to 1:45 PM the following deficiencies were found: 1. No CO detector coverage in the hallway of the second floor 2. No CO detector coverage in the hallway of the first floor. 3. No CO detector coverage in Resident Room	K 130		

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K 130	Continued From page 3 102 These findings were acknowledged by the Maintenance Director.	K 130	**K144** **Plan to correct identified findings:** An education was performed to the Maintenance Director to ensure Emergency Power test monthly are performed. **Identification similar situation:** An education was performed to the Maintenance Director to ensure monthly Emergency Power testing are performed. **Measures to prevent recurrence:** Maintenance Director has been provided forms for tracking Emergency Power Testing.. The Maintenance Director has been sign up for the TELS program to monitor, track and trend. **Monitor to sustain compliance:** The Maintenance Director and/or designee will audit the process of Emergency Power Testing Results will forwarded to Quality Assurance Committee for the next 90 days.	11-8-13
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This Standard is not met as evidenced by: Based on record review and staff interview, the facility failed to assure that emergency power was available during primary power outage in accordance with NFPA 99, 3-4.4.2 requiring documentation of testing, maintenance and repairs of the generator. This potentially affected all residents to loss of illumination of exit egress, fire and smoke alarms during a power outage. Findings include: 1. During a record review of the generator maintenance log on October 15, 2013 at 12:30 PM, the facility failed to maintain a proper log showing that the generator had been placed under a load in the past 12 months for : May, June, July, August, September 2013 2. During a record review of the generator maintenance log on October 15, 2013 at 12:40 PM, the facility failed to maintain a proper log showing that the generator had been inspected	K 144		

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K 144	Continued From page 4 weekly for the past 12 months for: May, June, July, August, September 2013. This deficiency was acknowledged by the Maintenance Director.	K 144	**K147** **Plan to correct identified findings:** Second Floor Soiled Utility room by Resident Room 202 hand cleaner was removed. Hand Sanitizer was removed in Social Worker Office. Multi Plug device was removed from the Kitchen Manager Office. Extension Cord was removed and multi plug adapter was removed from Laundry Area. **Identification similar situation:** An audit was completed of the facility to ensure hand sanitizers are in proper locations, Multi plugs are properly used, and extension cords not in usage. **Measures to prevent recurrence:** Maintenance Director and/or designee will perform an education to staff to ensure hand sanitizers are in proper place, Multi plugs are properly used, and extension cords not in usage. The Maintenance Director has initiated the TELS program to monitor, track, and trend. **Monitor to sustain compliance:** The Maintenance Director and/or designee will perform random audits to ensure hand sanitizer is in proper location, Multi plugs are properly used, and extension cords are not in use in the facility. Results will forwarded to Quality Assurance Committee for the next thirty Days.	11-8-13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based on observations, the facility failed to maintain proper electrical conditions per NFPA 70, National Electrical Code. This has the potential to expose staff and patients to a fire environment. The findings are as follows: During the facility tour on October 15, 2013 from 9:30 AM to 1:45 PM the following deficiencies were identified: 1. 2nd floor Soiled utility room by Res Room 202 - hand cleaner above electrical source 2. Social Worker Office - hand sanitizer above electrical source 3. Kitchen Mgr Office - multi plug device plugged into multi plug device 4. Laundry - extension cord powering a multi plug adapter These findings were acknowledged by the Maintenance Director	K 147		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 505362	DATE SURVEY COMPLETE: 10/15/2013
NAME OF PROVIDER OR SUPPLIER **FOREST VIEW TRANSITIONAL HEALTH CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **5129 HILLTOP ROAD EVERETT, WA. 98203**	

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 012	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This Standard is not met as evidenced by: Based upon observations and staff interviews on October 15, 2013 between approximately 9:30 AM and 1:45 PM has failed to maintain fire resistive construction of the building capable of resisting the passage of smoke and fire into other compartments. This could allow the toxic product of combustion to move out of a room and into the exit access corridor and the smoke compartment which would endanger the residents, staff and/or visitors within the facility. The findings include, but are not limited to: 1. The wall behind the door on the first floor of the back stairwell has a hole approximately the size of a baseball due to the door handle. The above was discussed and acknowledged by the Maintenance Director.
K 018	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This Standard is not met as evidenced by: Based on observation and staff interview the facility failed to assure that door openings closed to resist the passage of smoke to corridors. This potentially exposed residents to a smoke/fire environment. Findings include: During the facility tour on October 15, 2013 from 9:30 AM to 1:45 PM it was observed that the following doors did not close, latch or open properly when tested: 1. 2nd floor nurses station work office - wedged open

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The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 505362	DATE SURVEY COMPLETE: 10/15/2013
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 018	Continued From Page 1 2. Social worker office - wedged open 3. 1st floor nurses station work office - wedged open These findings were acknowledged by the facility Maintenance Director. All three deficiencies were corrected immediately
K 064	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This Standard is not met as evidenced by: Based on observation and record review, the facility failed to assure fire extinguishers are properly maintained. This potentially delays a quick response to contain a fire from spreading, exposing residents to fire in the environment. During the facility tour on October 15, 2013 from 9:30 AM to 1:45 PM, observed fire extinguisher in the following location where the top of the fire extinguisher exceeded 5 feet above the floor: 1. Kitchen store room The Maintenance Director acknowledged the findings.

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The above isolated deficiencies pose no actual harm to the residents

K012

Plan to correct identified findings: The wall behind the door on the first floor was repaired.

Identification similar situation: An audit was completed by the Maintenance Director to ensure no holes were present in the drywall in the facility.

Measures to prevent recurrence: Maintenance Director and/or designee will perform an audit of the facility walls to ensure no other holes are present in the dry wall.

Monitor to sustain compliance: The Maintenance Director and/or designee will perform random audits to ensure no holes in dry wall. Results will be forwarded to Quality Assurance Committee for the next thirty Days.

K018

Plan to correct identified findings: Wedges were removed from Social Worker Office, 1st Floor Nurses Station work office, 2nd Floor Nurses Station Work Office.

Identification similar situation: An audit was completed of the facility to ensure wedges are not being used in doors.

Measures to prevent recurrence: Maintenance Director and/or designee will perform an education to staff regarding wedges are not used in doors

Monitor to sustain compliance: The Maintenance Director and/or designee will perform random audits to ensure no wedges are in use at the facility. Results will forwarded to Quality Assurance Committee for the next thirty days.

K064

Plan to correct identified findings: Fire Extinguisher in the kitchen was moved down to proper level in kitchen store room.

Measures to prevent recurrence: An audit was performed in the facility to ensure Fire Extinguishers in facility are at proper level.

Monitor to sustain compliance: The Maintenance Director will report findings of audit of fire extinguishers to the proper levels to the QA/QI Committee. Results will forwarded to Quality Assurance Committee for the next thirty Days.